MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

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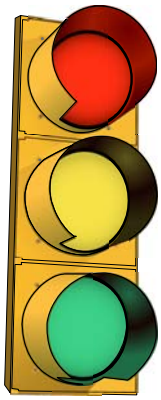
October 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Physicians billing Medicare Fiscal Intermediaries (FIs) or Regional Home Health Intermediaries (RHHIs) for Part B drugs; and Providers billing Medicare FIs for services paid under the OPPS

Provider Action Needed



STOP – Impact to You

This article is based on information contained in Change Request (CR) 4035, which describes changes to the OPPS to be implemented in the October 2005 OPPS update and changes to payment policy and billing procedures under the OPPS.

CAUTION – What You Need to Know

Unless otherwise noted, all changes addressed in CR4035 are effective for services furnished on or after October 1, 2005.

GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this article for further details regarding the October 2005 OPPS update.

Background

This article describes changes to the OPPS to be implemented in the October 2005 OPPS update. The October 2005 OPPS Outpatient Code Editor (OCE) and OPPS PRICER will reflect additions, changes, and deletions to the following:

- The Healthcare Common Procedure Coding System (HCPCS);
- Ambulatory Payment Classification (APC);
- HCPCS Modifiers; and

- Revenue Codes.

Key OPPS changes for October 2005 (unless another date is specified) are described below.

Note: October 2005 revisions to the OPPS OCE data files, instructions, and specifications are provided in CR4007, "October 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.3". An MLN Matters article (MM4007) addressing those changes is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4007.pdf on the CMS web site.

1. Expansion of the Device Dependent Edits

The Centers for Medicare & Medicaid Services (CMS) implemented the first phase of device edits in the OCE, effective April 1, 2005. These edits return claims for services to providers when:

- There is an HCPCS code for the device; and
- The provider failed to include a code for a major device necessary to perform the procedure.

CMS is expanding device edits to apply to more procedure codes for which the use of a device is essential to the performance of the procedure (effective October 1, 2005).

See CR4017, "Billing for Devices Under the Hospital Outpatient Prospective Payment System (OPPS)," at http://www.cms.hhs.gov/transmittals/downloads/R658CP.pdf on the CMS web site. Device edits can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS web site. They have been posted and open to public comment since the issuance of the 2005 OPPS Final Rule on November 1, 2004, and CMS incorporated many of the comments received into the device edits for implementation on October 1, 2005.

Please note that there are some HCPCS codes for procedures that require a device but for which there are no device edits. This is ***not*** an oversight. In some cases:

- The device codes that exist do not describe all possible devices that could be used in the procedure. Therefore, an edit could return a claim that properly coded the procedure, ***but*** omitted the device ***because*** there is not an appropriate code for the device that was used.
- The procedure is not on the list of procedures that have received adjusted payment and special scrutiny in the past. Therefore, no device editing is being applied at this time.

CMS may expand the device edits in the future. Comments or questions about the content of the edits should be directed to Outpatientpps@cms.hhs.gov. The person making the comment should:

- Identify the writer and the HCPCS code involved; and
- Include the rationale for why the person believes that the edit of concern should be revised.

Claim-specific questions should be directed to your Fiscal Intermediary.

2. No Cost Device Billing Clarification

In CR3915 (Transmittal 585, dated June 17, 2005), CMS provided directions for reporting devices for which the hospital incurs no cost. That CR stated that if hospitals paid under the OPPS surgically implant a device furnished at no cost to the hospital, the hospital must:

- Report a charge of zero for the device; or
- Submit a token charge (e.g. $1.00) on the line with the device code if the hospital's billing system requires that a charge be entered.

However, since the Fiscal Intermediary Standard System (FISS) will only accept a zero for lines reflecting a surgical procedure, hospitals should submit a token charge (e.g., $1.00) on the line with the device code and not report a zero charge as previously stated in CR3915.

3. New Service

The following new service is assigned for payment under the OPPS:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Adjusted Copayment
C9725	10/01/05	S	1507	Place endorectal app	Placement of endorectal intracavity applicator for high intensity brachytherapy	$550.00	$110.00

4. Payment for New Brachytherapy Sources

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 621(b)) established separate payment for brachytherapy devices, consisting of a seed or seeds (or radioactive source), based on the hospital's charges for the source(s) adjusted to cost (effective January 1, 2004, through December 31, 2006).

CR3154 (Transmittal 132, dated March 30, 2004) provided instructions regarding the change to billing and payment for brachytherapy sources and identified the applicable codes that became effective for this payment as of January 1, 2004. CR3154 can be found at: http://www.cms.hhs.gov/transmittals/Downloads/R132CP.pdf on the CMS web site.

The following table lists one new code that may be reported for payment as a brachytherapy source under the OPPS:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor
C2637	10/01/05	H	2637	Brachytx, Ytterbium - 169	Brachytherapy source, Ytterbium-169, per source

5. Drugs and Biologicals

a. Drugs with Payments Based on Average Sales Price (ASP) Effective October 1, 2005

The table below lists the drugs and biologicals whose payments under the OPPS will be established in accordance with the Average Sales Price (ASP) methodology that is used to calculate payment for drugs and biologicals in the physician office setting.

In the 2005 OPPS Final Rule (Federal Register ,Volume 9, Number 219, page 65777 (69 FR 65777)), it was stated that payments for drugs and biologicals based on ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary, CMS will:

- Incorporate changes to the payment rates in the appropriate quarterly release of the OPPS PRICER; and
- Not publish the updated payment rates in the program instructions implementing the associated quarterly update of the OPPS.

However, the updated payment rates will be available in the October 2005 update of OPPS Addendum A and Addendum B. These can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS web site. Single-indication orphan drugs payable under OPPS are also listed below. The methodology used to establish payment rates for these drugs is discussed in the 2005 OPPS Final Rule, published in the Federal Register (Volume 69, Number 219, page 65807 (69 FR 65807)) on November 15, 2004. It can be reviewed at http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=keyword&filterValue=1427&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS051449

on the CMS web site. (file CMF-1427-FC must be downloaded (35MB) and unzipped. Page 65807 is contained as file CMS1427FC_3.pdf)

HCPCS	APC	Long Description
C9123	9123	Human fibroblast derived temporary skin substitute, per 247 square centimeters
C9127	9127	Injection, paclitaxel protein-bound particles, per 1 mg
C9128	9128	Injection, pegaptamib sodium, per 0.3 mg
C9129	9129	Injection, Clofarabine, per 1 mg
C9203	9203	Injection, Perflexane lipid microspheres, per single use vial
C9205	9205	Injection, Oxaliplatin, per 5 mg
C9206	9206	Collagen-glycosaminoglycan bilayer matrix, per cm2
C9211	9211	Injection, Alefacept, for intravenous use per 7.5 mg
C9212	9212	Injection , Alefacept, for intramuscular use per 7.5 mg
C9218	9218	Injection, azacitidine, 1 mg
C9220	9220	Sodium hyaluronate per 30 mg dose, for intra-articular injection
C9221	9221	Acellular dermal tissue matrix, per 16cm2
C9222	9222	Decellularized soft tissue scaffold, per 1 cc
C9224	9224	Injection, Galsulfase, per 5 mg

HCPCS	APC	Long Description
C9225	9225	Injection, Fluocinolone acetonide intravitreal implant, per 0.59 mg
C9226	9226	Injection, Ziconotide for intrathecal infusion, per 5 mcg
J0128	9216	Abarelix for injectable suspension, per 10 mg
J0135	1083	Injection, adalimumab, 20 mg
J0180	9208	Injection, IV, Agalsidase beta, per 1 mg
J0205	900	Injection, Alglucerase, per 10 units
J0256	901	Alpha 1 proteinase inhibitor-human, 10 mg
J0595	703	Injection, Butorphanol tartrate 1 mg
J0878	9124	Injection, daptomycin per 1 mg
J1457	1085	Injection, gallium nitrate, 1 mg
J1785	916	Injection imiglucerase, per unit
J1931	9209	Injection, laronidase, 0.1 mg
J2185	729	Injection, meropenem, 100 mg
J2280	1046	Injection, moxifloxacin 100 mg
J2355	7011	Oprelvekin injection, 5 mg
J2357	9300	Injection, omalizumab, per 5 mg
J2469	9210	Injection, palonosetron HCl, 25 mcg
J2783	738	Injection, rasburicase, 0.5 mg
J2794	9125	Injection, risperidone, long acting, 0.5 mg
J3240	9108	Injection Thyrotropin Alpha , 0.9 mg, provided in 1.1 mg vial
J3411	1049	Injection, Thiamine HCL 100 mg
J3415	1050	Injection, Pyridoxine HCL 100 mg
J3465	1052	Injection, voriconazole, 10 mg
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg
J7308	7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354mg)
J7513	1612	Daclizumab, parenteral, 25 mg
J7518	9219	Mycophenolic acid, oral, per 180 mg
J7674	867	Methacholine chloride administered as inhalation solution through a nebulizer, per 1mg
J8501	868	Aprepitant, oral, 5 mg
J9010	9110	Alemtuzumab, 10 mg
J9015	807	Aldesleukin, per single use vial
J9017	9012	Arsenic trioxide, 1 mg
J9035	9214	Injection, Bevacizumab, per 10 mg
J9041	9207	Injection, Bortezomib, 0.1 mg
J9055	9215	Injection, Cetuximab, per 10 mg
J9160	1084	Denileukin diftitox, 300 mcg
J9216	838	Interferon gamma 1-b, 3 million units
J9300	9004	Gemtuzumab ozogamicin, 5 mg
J9305	9213	Injection, Pemetrexed, per 10 mg
Q2019	1615	Injection, Basiliximab, 20 mg

HCPCS	APC	Long Description
Q4075	1062	Injection, Acyclovir, 5 mg
Q4076	1070	Injection, Dopamine HCL, 40 mg
Q4077	1082	Injection, Treprostinil, 1 mg
Q4079	9126	Injection, Natalizumab, per 1 mg

b. Updated Payment Rates for Certain Drugs and Biologicals, Effective July 1, 2005, through September 30, 2005

The payment rates for the drugs and biologicals listed in the following table were **incorrect** in the July 2005 OPPS PRICER. The corrected payment rates will be installed in the October 2005 OPPS PRICER, effective for services furnished on July 1, 2005, through implementation of the October 2005 update. The FISS maintainer will mass-adjust claims that were processed incorrectly as a result of the incorrect rates in the July PRICER.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Adjusted Copayment
C9129	9129	Inj clofarabine	$29.21	$5.84
C9211	9211	Inj, alefacept, IV	$593.60	$118.72
J0595	0703	Butorphanol tartrate 1 mg	$0.94	$0.19
Q4075	1062	Acyclovir, 5 mg	$0.03	$0.01

c. Newly Approved Drugs and Biologicals Eligible for Pass-Through Status

The following drugs and biologicals have been designated as eligible for pass-through status under the OPPS, effective October 1, 2005. Payment rates for these items will be available in the October 2005 update of OPPS Addendum A and Addendum B at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS web site.

HCPCS	APC	SI	Long Description
C9225	9225	G	Injection,fluocinolone acetonide intravitreal implant, per 0.59 mg
C9226	9226	G	Injection, ziconotide for intrathecal infusion, per 5 mcg

d. Payment for Drugs and Biologicals Recently Approved by the FDA

CR3287 (Transmittal 188, dated May 28, 2004) explains how hospitals may report new drugs and biologicals after the Food and Drug Administration (FDA) approval but before assignment of product-specific HCPCS codes. CR3287 can be found at http://www.cms.hhs.gov/transmittals/Downloads/R188CP.pdf on the CMS web site.

Beginning in 2004, the MMA required that payment for new drugs and biologicals (after FDA approval but before assignment of product-specific HCPCS codes) be equal to 95 percent of Average Wholesale Price (AWP). CMS is assigning the following product-specific HCPCS code for billing a biological that was approved by the FDA on May 31, 2005. The payment rate for this item can be found in the October 2005 update of OPPS Addendum A and Addendum B on the CMS web site.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Effective Date
C9224	K	9224	Injection, galsulfase	Injection, galsulfase, per 5 mg	5/31/2005

Hospitals should bill for this biological using the following codes:

- HCPCS code C9399 (Unclassified Drug or Biological) for claims submitted prior to successful implementation of the October 2005 OPPS OCE (in accordance with CR 3287 (Transmittal 188, dated May 28, 2004)); and
- HCPCS code C9224 for claims submitted on or after implementation of the October 2005 OPPS OCE. Note that claims submitted with C9399 after October 3, 2005, will be returned to the provider.

e. Change in the Effective Date of HCPCS Code J8501 (Aprepitant, oral, 5 mg)

CMS stated in the July 2005 update of the OPPS that *pass-through status* for HCPCS code J8501 (Aprepitant, oral, 5mg) was approved effective April 6, 2005. However, a National Coverage Decision (NCD) announced that oral Aprepitant (HCPCS code J8501) had an effective date of April 4, 2005. Therefore, in CR4035, CMS changes the pass-through status for J8501 (Arprepitant, oral, 5mg) to an effective date of April 4, 2005.

CMS further instructs in CR4035 that on or after the implementation of the October 2005 OPPS OCE, your Medicare intermediary will mass-adjust claims containing HCPCS code J8501 with date of service April 4, 2005, or April 5, 2005, processed prior to installment of the October 2005 OPPS PRICER.

6. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned an HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program. It only indicates how the product, procedure, or service may be paid **if** it were covered by the program. Fiscal Intermediaries determine whether a drug, device, procedure, or service meets all program requirements for coverage; for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

Hospital Outpatient Prospective Payment System-related information can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS web site.

For complete details, please see the official instruction issued to your FI or RHHI regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/transmittals/downloads/R691CP.pdf on the CMS web site.

If you have any questions, please contact your FI or RHHI at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf on the CMS web site.